

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12023

CERTIFICATE OF DEATH

12005

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester Co</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>none</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>George E Blake</u>		4. DATE OF DEATH <u>10 22 19 59</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-1885</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Claton Blake</u>		14. MOTHER'S MAIDEN NAME <u>Ella Leonard</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		
17. INFORMANT <u>Chauncy Blake</u> Address <u>Berlin</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of liver with metastases</u> 156X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 mos</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>2-17-19-59</u> to <u>10-20-19-59</u> , that I last saw the deceased alive on <u>10-20-19-59</u> , and that death occurred at <u>8:55 P.M.</u> from the causes and on the date stated above.				
ACTUAL SIGNATURE <u>Wm. H. Sully, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Berlin md</u> DATE SIGNED <u>10-26-59</u>		
PHYSICIAN'S NAME (Type) <u>Ivory U. Sully, Jr. MD</u>		<u>Berlin, Md</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-27-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Emgreen Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Berlin md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M. West</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>OCT 30 1959</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF
1902
CERTIFICATE OF DEATH

MASSACHUSETTS
BUREAU OF
VITAL RECORDS
1902

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Place of birth: _____
6. Date of death: _____
7. Place of death: _____
8. Cause of death: _____
9. Signature of physician: _____
10. Signature of registrar: _____
11. Date of registration: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12006

12021

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City	c. LENGTH OF STAY IN 1b minutes	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42 Pocomoke City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Corner of Front and Vine Streets		d. STREET ADDRESS 19 Clarke Avenue	
3. NAME OF DECEASED (Type or print) MAURICE WRIXAM BOSTON		4. DATE OF DEATH Month October Day 1 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14, 1891
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garage owner		10b. KIND OF BUSINESS OR INDUSTRY Automobile	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Jacob J. Boston		14. MOTHER'S MAIDEN NAME Janie Pilchard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes WW #1		16. SOCIAL SECURITY NO. 214-32-6735	
17. INFORMANT Mrs Nona W. Boston, Pocomoke City, Md.		Address 19 Clarke Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Obstruction DUE TO (b) Sudden death Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Unusually heavy day's work			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE N. E. Sartorius Sr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) N. E. SARTORIUS SR.		DATE SIGNED Oct 2 '59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-4-59	22c. NAME OF CEMETERY Salem Methodist	22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Humphreys Watson		ADDRESS Pocomoke City, Md.	
24a. REC'D BY REGISTRAR DATE OCT 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knapp	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12051

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12007

Reg. Dist. No.

**FOR STATE
HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY <u>Worcester</u>		2. USUAL RESIDENCE (When deceased lived. If institution, Residence before admission) a. STATE <u>Md</u>		b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>		c. LENGTH OF STAY IN lb <u>10 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>42 Pocomoke City</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>505 Laurel St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Ballard Dixon</u>		4. DATE OF DEATH Month <u>10</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>m</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 8-1931</u>	9. AGE (In years last birthday) <u>28</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canning factory</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
13. FATHER'S NAME <u>John Dixon</u>		14. MOTHER'S MARRIAGE NAME <u>Maggie Ballard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>218-245250</u>		17. INFORMANT <u>Jeannette Dixon</u> Address <u>Pocomoke City Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abdominal Hemorrhages</u> 981X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>gun shot wound</u> DUE TO (c) <u>Homicide</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Been drinking whiskey</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot by father-in-law</u>			
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u>at home</u>	
20f. (City or town) <u>Pocomoke</u>		20g. (County) <u>Worcester</u>		20h. (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>N.E. Sartorius</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10/24/59</u>	
EXAMINER'S NAME (Type) <u>N.E. Sartorius</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (specify) <u>Burial</u>		22b. DATE THEREOF <u>10-29-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Halls Hill</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Whorton</u>		ADDRESS <u>New Church, W.</u>		24a. REC'D BY REGISTRAR <u>Nov 3 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hays</u>	

DATE OF DEATH
TIME OF DEATH

[Faint, mostly illegible handwritten text and markings on the form, including what appears to be a signature and various notations.]

[Faint, mostly illegible text on the right margin, possibly a date and time.]

CERTIFICATE OF DEATH

Reg. Dist. No.

12008

12024

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Branch St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELLINGRA FRANKLIN		4. DATE OF DEATH Month Day Year 10 19 1959	
5. SEX F.M.	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-18-1889
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY FACTORY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Will Robin		14. MOTHER'S MAIDEN NAME Roda	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 219-03-6646	
17. INFORMANT THRS. Vivian Garris, Berlin, TMD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X UREMIA DUE TO Hypertensive Cardio-vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 7 days (c) Several years		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-8 , 19 59 , to 10-17 , 19 59 , that I last saw the deceased alive on 10-17 , 19 59 , and that death occurred at 2:50 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Irving U. Sully, Jr. M.D.		ADDRESS (Street, city or town, state) Berlin Md	
PHYSICIAN'S NAME (Type) DR. Ivory U Sully, Jr. Berlin, TMD.		DATE SIGNED 10/21/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-21-59	
22c. NAME OF CEMETERY OR CREMATORY Evergreen Cem.		22d. LOCATION (City, town, or county) (State) Berlin, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Thornton B. Solley-Salisbury, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE OCT 26 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAM B. BOWEN

Blank lines for text entry on the certificate form.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> c. LENGTH OF STAY IN 1b <u>18 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>B.</u> Last <u>Graham</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>28</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 30 - 1867</u>	9. AGE (In years last birthday) <u>92-0-38</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Rock West Virginia</u>	
13. FATHER'S NAME <u>Martin Hatfield</u>		14. MOTHER'S MAIDEN NAME <u>Martina McAllister</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>Mrs. S. Otis Graham, Snow Hill, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis with</u> <u>331X</u> DUE TO <u>renal, cerebral, cardiac deterioration</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>cerebral accident</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>9 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Oct 1957</u> to <u>Oct 28, 1959</u> that I last saw the deceased alive on <u>Oct 27</u> , 1959, and that death occurred at <u>9:00 P.</u> M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Paul Cohen</u>		M.D. <u>Snow Hill, Md</u>		DATE SIGNED <u>10/29/59</u>	
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Oct 31/59</u>		<u>Whitcomb Cemetery</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton E. Ginn</u>		ADDRESS <u>Snow Hill, MD</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 30 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

VS A15 (4)
ISM 9/58

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12026
CERTIFICATE OF DEATH

12010

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before adm'ssion) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin			c. LENGTH OF STAY IN TB 2 months			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Stockton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Berlin Nursing Home				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) MINNIE		First EMMA		Middle MATTHEWS		Last	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 4, 1877	
9. AGE (In years, last birthday) 82		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		4. DATE OF DEATH Month October Day 5 Year 1959	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Alfred Smith				14. MOTHER'S MAIDEN NAME Mary Marshall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Reginald W. Matthews, Girdletree, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chr Myocarditis 12X DUE TO (b) Chr Nephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (c) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 2 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-1-1959 , to 10-5-1959 , that I last saw the deceased alive on 10-4-1959 , and that death occurred at 7:45 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Chas. R. Law				ADDRESS (Street, city or town, state) Berlin Md		DATE SIGNED 10-5-59	
PHYSICIAN'S NAME (Type) Charles R. Law							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-7-59		22c. NAME OF CEMETERY Union Methodist		22d. LOCATION (City, town, or county) (State) Worcester County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Watson				ADDRESS Pocomoke Md		24a. REC'D BY REGISTRAR DATE OCT 9 '59	
				24b. REGISTRAR'S SIGNATURE William E. House			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12011

Reg. Dist. No.

12027

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BERLIN</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>LEE</u> Last <u>PARSONS</u>				4. DATE OF DEATH Month <u>OCT</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 16, 1936</u>	9. AGE (in years last birthday) <u>23</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNEMPLOYED</u>		11. BIRTHPLACE (State or foreign country) <u>PITTSVILLE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>RALPH PARSONS</u>				14. MOTHER'S MAIDEN NAME <u>PAULINE DENNIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>MR. RALPH PARSONS MILTON DEL</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Shock, Exsanguination,</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Traumatic Amputation, both legs, 2nd 3rd</u> DUE TO (c) <u>finger rt hand, 3,4,5 finger lt hand, Multiple Contus.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by railroad while lying over track</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>4:50</u> a. m. <u> </u> p. m. <u> </u> <u>10/24/59</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Railroad track Berlin, Worcestor Co. Md.</u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Herman A. Robbins</u> EXAMINER'S NAME (Type) <u>Herman A Robbins M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/27/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS</u>		22d. LOCATION (City, town, or county) (State) <u>PITTSVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anne A Barbage Berlin Md</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>OCT 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hunt</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

12003

James H. H. H. H.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/58

12028

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12012

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Widdletown Rural #1</u>		c. LENGTH OF STAY IN MD <u>6 years</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Widdletown Rural #1</u>		d. STREET ADDRESS <u>Widdletown Rural #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bella</u> Middle <u>D</u> Last <u>Truitt</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 22 - 1905</u>
9. AGE (In years last birthday) <u>53/10/9</u>		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>	
11. BIRTHPLACE (State or foreign country) <u>Baldwinville, N.D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George S. Davis</u>		14. MOTHER'S MAIDEN NAME <u>Millie Harrington</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, and date) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-124-606</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20e. (City or town) <u> </u>		20f. (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>10/30/59</u> , 19 <u> </u> , to <u>10/31/59</u> , 19 <u> </u> , that I last saw the deceased alive on <u>10/31/59</u> , 19 <u> </u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Cohen</u> M.D.		DATE SIGNED <u>Nov 11/2/59</u>	
PHYSICIAN'S NAME (Type) <u>Paul Cohen</u>		ADDRESS (Street, city or town, state) <u> </u>	
22. BURIAL, CREMATION, ETC., DATE THEREOF Removal (Specify) <u>10/3/59</u>		22a. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>	
22b. LOCATION (City, town, or county) (State) <u>Widdletown, md</u>		22c. REC'D BY REGISTRAR <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>May E. Dimmis</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

1801

CHURCH OF ST. MARY

1801

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]